

(i) The same methodology used in establishing the initial baseline; or

(ii) Another methodology based on new information that enables the State to establish a new baseline.

(3) If a new methodology is used, the State must also provide annual estimates based on either the March supplement to the CPS or the methodology used to develop the initial baseline.

[66 FR 2683, Jan. 11, 2001, as amended at 66 FR 33824, June 25, 2001]

Subpart H—Substitution of Coverage

SOURCE: 66 FR 2684, Jan. 11, 2001, unless otherwise noted.

§ 457.800 Basis, scope, and applicability.

(a) *Statutory basis.* This subpart interprets and implements section 2102(b)(3)(C) of the Act, which provides that the State plan must include a description of procedures the State uses to ensure that health benefits coverage provided under the State plan does not substitute for coverage under group health plans.

(b) *Scope.* This subpart sets forth State plan requirements relating to substitution of coverage in general and specific requirements relating to substitution of coverage under premium assistance programs.

(c) *Applicability.* The requirements of this subpart apply to separate child health programs.

§ 457.805 State plan requirement: Procedures to address substitution under group health plans.

The State plan must include a description of reasonable procedures to ensure that health benefits coverage provided under the State plan does not substitute for coverage provided under group health plans as defined at § 457.10.

§ 457.810 Premium assistance programs: Required protections against substitution.

A State that operates a premium assistance program, as defined at § 457.10, must provide the protections against substitution of CHIP coverage for cov-

erage under group health plans specified in this section. The State must describe these protections in the State plan; and report on results of monitoring of substitution in its annual reports.

(a) *Minimum period without coverage under a group health plan.* For health benefits coverage provided through premium assistance for group health plans, the following rules apply:

(1) An enrollee must not have had coverage under a group health plan for a period of at least 6 months prior to enrollment in a premium assistance program. A State may not require a minimum period without coverage under a group health plan that exceeds 12 months.

(2) States may permit reasonable exceptions to the requirement for a minimum period without coverage under a group health plan for—

(i) Involuntary loss of coverage under a group health plan, due to employer termination of coverage for all employees and dependents;

(ii) Economic hardship;

(iii) Change to employment that does not offer dependent coverage; or

(iv) Other reasons proposed by the State and approved as part of the State plan.

(3) The requirement for a minimum period without coverage under a group health plan does not apply to a child who, within the previous 6 months, has received coverage under a group health plan through Medicaid under section 1906 of the Act.

(4) The Secretary may waive the 6-month waiting period requirement described in this section at her discretion.

(b) *Employer contribution.* For health benefits coverage obtained through premium assistance for group health plans, the employee who is eligible for the coverage must apply for the full premium contribution available from the employer.

(c) *Cost effectiveness.* In establishing cost effectiveness—

(1) The State's cost for coverage for children under premium assistance programs must not be greater than the cost of other CHIP coverage for these children; and